West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 12th January 2021		Agenda item: 09/21	
Report title:	**Joint Committee work plan – implementation update and risks to delivery**		
Joint Committee sponsor:	Chair		
Clinical Lead:	Not applicable		
Author:	Stephen Gregg, Governance Lead		
Presenter:	Stephen Gregg		
Purpose of report: (why is this being brought to the Committee?)			
Decision		Comment	✓
Assurance	✓		

Executive summary

Implementing the Joint Committee work plan

At its Development session in December 2020, the Joint Committee requested an update on the implementation of the commissioning decisions and recommendations covered by its work plan. This report provides a high level summary of progress against those decisions and recommendations and will form the basis of the Joint Committee's 2020/21 annual report.

Risk management

The Joint Committee has agreed an approach to reviewing and managing the risks to the delivery of its work plan. Risks are given a score of 1-5 for likelihood and 1-5 for impact. These scores are then multiplied to give the total risk score. All risks scored at 12 or above after mitigation are reported to the Committee

The significant risks to the delivery of the plan have been reviewed and are attached at **Appendix 1.** Controls, assurances and planned mitigating actions are set out for each risk. There are currently 7 risks scored at 12 or above after mitigation:

Cancer
1.1 Impact of COVID19 on diagnostic capacity (risk score – 12)

Improving Planned care
4.1 Hydroxychloroquinine monitoring (12)
4.2 Workforce (12)
4.3 Flash glucose monitoring (12)
4.4 Eye care services (16)
4.5 MSK implementation (12)
4.6 Digital (12)

Recommendations and next steps	
The Joint Committee is asked to: a) **Note** the update on the implementation of Joint Committee decisions and recommendations. b) **Review** the risk to delivery of its workplan and comment on the actions being taken to mitigate identified risks.	
Delivering outcomes: describe how the report supports the delivery of outcomes (Health and wellbeing, care and quality, finance and efficiency)	
The Joint Committee work plan focuses on the delivery of priority outcomes.	
Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	A key element of the work plan and critical path for Joint Committee decisions.
Public involvement:	As above.
Finance:	As above.
Risk:	The refreshed risk framework is attached at Appendix 1.
Conflicts of interest:	None identified.

Joint Committee work plan – implementing commissioning decisions and recommendations

Introduction

1. This report provides a high level summary of progress against the decisions and recommendations covered by the Joint Committee's work plan and will form the basis of the Joint Committee's 2020/21 annual report.

Urgent and emergency care

2. In December 2018, the Joint Committee approved a recommendation to appoint Yorkshire Ambulance Service (YAS) as the preferred bidder for the Integrated Urgent Care Clinical Assessment Service (NHS111), which is commissioned on a Yorkshire & Humber basis. Since its start from April 2019, it has played a pivotal role in integration of urgent care services across the system.

3. During the financial year 2020-21, which included the start of the COVID 19 pandemic, the service had triaged an unprecedented level of 1.197million calls (inclusive of November 2020) from patients across Y&H. One of the key aspects of the IUC service is the provision of remote clinical assessment of the patients who contact NHS111. This is currently delivered through YAS in house clinicians and local clinical advice services which is predominantly provided in West Yorkshire by Local Care Direct. In West Yorkshire, the LCD service has transformed during the COVID 19 pandemic from a majority face to face service model to a remote clinical hub triage model. From April to November 2020 nearly 50% of the patients were triaged through remote clinical assessment.

4. Direct booking from NHS111 into GP Practices became a mandatory part of the GP Contract in 2019, with all sites in WY&H now offering appointments. Due to the COVID 19 pandemic and changes in clinical settings, such as less initial face to face appointments, the booking is now into a clinical telephone appointment. Patients are remotely triaged to determine if there is a clinical need to be seen face to face. Patients are offered telephone consultations and video consultations, where appropriate.

Stroke

5. **Hyper-Acute Care -** The Joint Committee agreed a common approach for commissioning hyper acute stroke services and all stages from prevention to recovery. The specialist hyper-acute stroke pathways are now well established, with 4 units providing hyper-acute care during the first 72 hours following stroke across WY&H:
    - Bradford Teaching Hospitals NHS Foundation Trust – Bradford Royal Infirmary
    - Calderdale and Huddersfield NHS Foundation Trust – Calderdale Royal Hospital,
    - Leeds Teaching Hospitals NHS Trust – Leeds General Infirmary and;
    - Mid Yorkshire Hospitals NHS Trust – Pinderfields Hospital.

6. **Stroke network -** A sustainable stroke clinical network has been established, working to provide the best stroke services possible and further improve quality and stroke outcomes in each of our six places. Network priorities are to prevent strokes, deliver effective care when people have a stroke that meets the national standards, ensure there is good support and rehabilitation for people after a stroke and address workforce challenges. Key workstreams include the use of telemedicine, improving access and outcomes for patients following hospital discharge, implementing the clinical standards in the WY&H Whole Pathway Service Specification, establishing a patient and carer assurance and addressing health inequalities in line with the national clinical policy unit recommendations with particular emphasis on AF, Hypertension and Hypercholesterolemia.

7. **Atrial Fibrillation -** the Joint Committee led work to improve the detection and treatment of Atrial Fibrillation (AF), a fast and erratic heartbeat responsible for 1 in 5 strokes. It agreed simplified treatment guidance for people with high cholesterol which has reduced the number of people having heart attacks and strokes. 151 GP practices participated in the two year programme which led to increased detection of AF, with an additional 5,140 patients identified and increased protection, with an additional 5,064 patients diagnosed with AF receiving anticoagulation treatment. Based on the increased anticoagulation it is estimated that 155 AF related strokes were prevented.

Healthy Hearts

8. Following a recommendation from the Joint Committee, the CCGs adopted the Healthy Hearts improvement project, building on successful work in Bradford. The project aims to identify more people with high blood pressure, help them to control it better and as a result reduce the risk of heart attacks and strokes. To support the project, the Committee approved simplified guidance for treating high blood pressure in adults aged below 80.

9. Data from October 2020 shows that the Healthy Hearts project has seen almost 6,000 patients either switched to a more effective statin or offered a statin to those at risk of CVD – helping to control cholesterol. There are 8,500 more patients on hypertension registers and around 19,500 more patients with blood pressure controlled to target levels. This has the potential to save an estimated 900 Cardiovascular disease (CVD) events over the next 5-10 years.

10. WY&H Healthy Hearts won the HSJ Cardiovascular Initiative of the Year award and the website is now even more accessible to the public and professionals with a range of features including; text-to-speech, translation support and easy read. The project is now in the final stages of planning phase three which will be focussed on Diabetes patients who are at high risk of CVD.

Improving planned care

11. The Joint Committee has agreed a number of clinical threshold policies since the start of the Improving Planned Care programme of work. These have resulted in improving equality of access criteria across WY&H and have also seen a reduction in some levels of elective surgery, where other more effective non-surgical interventions can be effective. Notably, following the introduction of the shoulder policy we have seen a reduction in the number of shoulder decompression operations, an intervention known to only work in specific circumstances. This has been about a 40% reduction in a 12 month period, although further reduction should now be very limited as the remaining procedures are likely to be for the right conditions. Following the introduction of the knee policy we have seen reductions in the numbers of knee arthroscopy procedures in people with osteoarthritis knee, again a procedure which is unlikely to be effective or remove the need for knee replacement. This reduction was about 30% in one year, however there may still be further improvement to be seen in this area.

12. The Evidence Based Interventions policies have been implemented across WY&H (list 1 procedures) and from the 2018 baseline there has been a 37% reduction in category 1 procedures and an 18% reduction in category 2 procedures. This equates to a reduction of almost 2500 procedures, which were interventions unlikely to provide benefit to the individuals. This has released capacity in surgical lists for more urgent and clinically effective activity to be undertaken.

13. The ophthalmology policies included standardisation of the clinical threshold for cataract surgery and for intervention for Age-related wet Macular Degeneration. These policies were implemented immediately and have equalised access across WY&H. The wider pathway implementation still requires further development and delivery and whilst progress is variable across the places of WY&H and disrupted significantly by the coronavirus pandemic which arrived at a similar time as these policies were agreed, all places are moving forward with implementation.

Mental Health, Learning Disability and Autism

14. The Joint Committee has supported work to develop a centre of excellence model for Assessment & Treatment Units, and supported comprehensive development in providing more appropriate Complex Rehabilitation services within West Yorkshire. Formal decisions on future commissioning arrangements for both of these will be taken during 2021, alongside work to bring CCG and specialised commissioning portfolios closer together, for example in Child and Adolescent Mental Health Services (CAMHS) and perinatal.

Cancer

15. Most commissioning of cancer services is carried out by Specialised Commissioning and most pathways are nationally designed, leaving limited scope for local variation. There is greater scope for local variation in relation to diagnosis and investigation. The Cancer Alliance work programme to support pandemic recovery, particularly with regard to embedding some diagnostic pathway innovations, has highlighted the importance of this. The scope of the Joint Committee's work programme has been extended to give delegated authority in these areas. This will enable the Joint Committee to take collaborative decisions on business cases, based on the outcome of pilot phases.

Recommendation

The Joint Committee is recommended to **note** the update on the implementation of Joint Committee decisions and recommendations.

Appendix 1

West Yorkshire and Harrogate Joint Committee of CCGs

Assurance Framework

Introduction

The Assurance Framework sets out how the Joint Committee will manage the principal risks to delivering agreed STP outcomes covered by the Committee's work plan. The Framework enables the Committee to assure itself (gain confidence, based on evidence). The framework aligns risks, key controls and assurances.

Where gaps are identified, or key controls and assurances are insufficient to reduce the risk of non-delivery, the Committee will agree the action that needs to be taken. Planned actions will enable the Committee to monitor progress in addressing gaps or weaknesses.

The Committee will:

- Monitor the principal risks that threaten the achievement of the outcomes covered by the Joint Committee's workplan.
- Evaluate the controls intended to manage these principal risks.
- Evaluate the assurance across all areas of principal risk.
- Identify positive assurances and areas where there are gaps in controls and / or assurances
- Put in place plans to take corrective action where gaps have been identified in relation to principal risks.

Risks are given a score of 1-5 for likelihood and 1-5 for impact. These scores are then multiplied to give the total risk score. The framework identifies risks with a score of 12 or more, after mitigating controls and assurances have been taken into account.

Joint Committee work plan	Risk to delivery	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
1. Cancer Develop and agree WY&H commissioning policies impacting on cancer care, including but not limited to: • Lynch syndrome testing • Optimal cancer pathways which deliver Constitutional standards • Tele dermatology services for suspected skin cancers • Rapid diagnostic centres • Personalised support for people living with and beyond cancer	1.1 The impact of COVID19 has reduced patient presentation with symptoms and capacity constraints have, and continue to extend waiting times. Risk assessment and prioritisation of cancer care mean the principal risks are delayed diagnosis leading to poorer survival outcomes, and inability to deliver NHS Constitutional standards. Delivering earlier diagnosis of cancer is one of the 10 big ambitions for the H&C Partnership	20 (5x4)	• Well established and functional Cancer Alliance Board • Well established, regular and robust relationships with WYAAT stakeholders • Regular data analysis and modelling to understand impact • Clear national strategy and prioritisation of cancer care • Commitment from WYAAT providers to protect and continue to prioritise capacity for time critical cancer care.	12 (3x4) No change since last meeting	• System-wide priorities agreed to align efforts of all stakeholders around recovery of referrals and maximisation of capacity for diagnosis and treatment. • Collection and ongoing analysis of data to understand 'missing' referrals and target encouragement to present where appropriate. • Investment of Alliance SDF in supporting programme of innovation implementation to aid case finding and clinical risk stratification to make best use of available capacity. Subject to impact assessment this may require consideration for business as usual. • Collaborative programme with Planned Care Alliance on key diagnostic capacity and demand.
2. Maternity Agree the approach to commissioning maternity services across WY&H including: • the specification, service standards and commissioning policy. • the commissioning and procurement approach	• No relevant risks currently scored at 12 or above.				

Joint Committee work plan	Risk to delivery	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
3. Mental Health, learning disability and autism • Agree a single operating model for the management of acute and psychiatric intensive care unit (PICU) beds. • Agree a standard commissioning approach to acute and PICU services and a commitment to peer review local crisis services. • Agree plan for the provision of children and young people inpatient units, integrated with local pathways. • Agree a collaborative commissioning model for Assessment and Treatment Units across West Yorkshire for people with learning disabilities to support the new operating model.	• No relevant risks currently scored at 12 or above.				

Joint Committee work plan	Risk to delivery	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
4. Improving Planned care Develop and agree WY&H commissioning policies, including, but not limited to: • Clinical thresholds and procedures of low clinical value; • Efficient prescribing. Develop and agree service specifications, service standards and the commissioning and procurement approach to support pathway optimisation, including outpatients transformation	4.1 Hydroxychloroquine: There is a cohort of people prescribed and taking Hydroxychloroquine/ chloroquine in the community across WY&H who are not being monitored to guard against the risk of avoidable sight loss. The ICS currently doesn't have an effective monitoring programme, and this will continue if the ICS does not commission a service to deliver one; heightening the risk of sight loss to people across WY&H. The capacity challenges faced by providers add to the difficulty in providing a service to monitor patients, and capacity challenges will present difficulty in having enough suitably qualified staff.	15 (5 x 3)	• A monitoring protocol follows issued guidance from the Royal College of Ophthalmologists	12 (4 x 3) No change since last meeting	• There will be local negotiations with NHS providers to see if something can be delivered within Hospital Eyecare Services. We will need to consider a System option if there's no success with this. There needs to be a relationship between hospital eye care services and the community to build capacity. The programme's plan to manage AMD, Cataracts and Glaucoma and eventually Diabetic Retinopathy demand for services will create capacity in the system in ensuring appropriate referrals and streamlining the discharge and follow up pathway and process to ensure that only appropriate patients are seen in outpatients. The pathway and policy were agreed at JCC in November 2019. An implementation meeting is planned for Q4 with a 3 year implementation plan. 1 place is ready to implement from 1 April 2020.
Improving planned care	4.2 There is a risk that transformational changes cannot be implemented (subject to outcome of consultation with key stakeholders) due to lack of available & appropriately skilled workforce or the current workforce unwilling to adapt to changes in working or to upskill to address any skills gap. This will affect the implementation of the WY&H MSK Pathway that has a target implementation period of 3 years and associated MSK policies have a period of 1 year. Without the appropriately skilled staff to deliver the services along the MSK pathway these implementation dates will not be met.	15 (3 x 5)	• Workforce information will need to be collected as part of the programme and a defined plan and strategy to work with the West Yorkshire & Harrogate Workforce Strategy Group to address workforce challenges. • Explicit mitigation action with LWAB to escalate the risk of the system being able to roll out FCPs to 15% of the population by 2020 against the risk of de-stabilising the system. • The role and uptake of FCPs and Pharmacists in Primary care networks will present challenges at Place and for LWAB to take responsibility where physiotherapists are taken from elsewhere in the system.	12 (3 x 4) No change since last meeting	• To maintain all other services, staff will need to be upskilled and Primary care networks will need to fund and develop these new roles. There is a need for a conversation with the primary and community care programme. Work with Health Education England (HEE) to proactively identify training needs and opportunities to develop workforce across different workstreams • Workforce development is needed and to bring to attention of HEE (revised partnership workforce) • Local Workforce Action Board – work with and identify skills gap and strategies to address. • Engage with workforce, Comms and Engagement Manager (internal comms strategy). Bid for first contact practitioners (FCP) implementation from LWAB across the ICS in June 2019, and primary and community pharmacists and optometrists' development: the biggest risk to the future sustainability of this programme. The outcome of the bid for FCP implementation received in August 2019 with £50k received. Other sources of funding to be researched with NHSE and the Primary and Community Programme across WY&H. We

Joint Committee work plan	Risk to delivery	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
					need to provide whatever support we can for our Places to be in a position to implement the MSK pathway and associated policies. • To support the eye care programme HEE are undertaking a workforce census in WY&H. in addition HEE will explore best practice in workforce models for dermatology and compare WY&H with good practice nationally.
Improving planned care	4.3 Flash Glucose monitoring prescribing levels	15 (5 x 3)	• We do not understand fully the impact of the actual and predicted prescribing levels following implementation of the flash glucose monitoring policy. Assurance of the evaluation policy undertaken by Joint Committee to address any negative impact of this policy.	12 (4 x 3) No change since last meeting	• Responsibility for evaluation has been clearly expressed by the Joint Committee in the minutes and action log. Pharmacy Leadership Group members will monitor actual prescribing spend against anticipated spend. This work will also be linked with the WY&H Diabetes programme.
Improving planned care	4.4 There is a need for disproportionate investment in eye care services over the next 5 years to meet increasing growth in demand. This will require investment in hospital and community eye services. Without this investment growth will not keep pace with demand and people will be at risk of preventable sight loss.	20 (4 x 5)	• Raise awareness through programme working groups including programme board, through shared leadership arrangements with WYAAT, and through WY&H Finance Forum. Bradford and Wakefield are already planning for now. Places need to consider planning for the growth in demand over the next 5 years.	16 (4 x 4) No change since last meeting	• Through implementation planning ensure need for additional investment is highlighted and escalated within organisations. Meeting of programme directors with Place based planned care arranged by NHSE/I regional director. Confidence that current spending plans will reflect this. There is an increased risk from COVID 19 that implementation planning in eye care services will be delayed.
Improving planned care	4.5 There is a need for clear plans for MSK implementation at place to reflect demographic growth and shift in investment to preventative and conservative management strategies. Without investment in MSK services secondary care demand will continue to grow. We want to stem the rate of growth.	16 (4 x 4)	• Raise awareness through programme working groups including programme board, through shared leadership arrangements with WYAAT, and through WY&H Finance Forum, and highlight the impact on the delivery of our programme.	12 (4 x 3) No change since last meeting	• Through implementation planning ensure need for additional investment is highlighted and escalated within organisations. Investment strategy to reflect future intentions. There is an increased risk from COVID 19 that implementation of the MSK pathway and the suite of MSK commissioning policies will be delayed.

Joint Committee work plan	Risk to delivery	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
Improving planned care	4.6 Technological advancement not progressing at the same pace as the programme to enable standardisation of commissioning policies and clinical thresholds and care pathways to be implemented at pace to deliver the identified outcomes, and achieve the realisable benefits within the programme's deliverables. This programme does not have the financial resource to support the creation of additional capacity.	20 (5 x 5)	• Ensure integration and collaboration with Digital programme of WYH HCP. Digitally enabling our population to engage with the programme: ensuring we include patient facing digitisation of the programme in collaboration with the digital programme of WYH HCP.	12 (3 x 4) No change since last meeting	• Engaging with primary care and secondary providers to identify gaps in technological advancement • Encouraging and engaging participation from technology advancement leads across the provider and commissioner sectors to support development of digital platforms to aid clinicians in directing patients along elective care pathways and in shared decision making with patients • Engaging with and working with NHS England, NHS Improvement and NHS Digital to address the gaps in technology or technological ability or functionality issues experienced by providers within the scope of the programme • WYAAT engagement • Link with NHS Digital – ERS • Trial in the ERS and ophthalmology referrals for optometrists via NHS Digital. • The programme director has become a member of the Digital Programme Board and the programme works collaboratively with the WYH HCP Digital Programme to explore the digital needs of the Improving Planned Care Programme.
5. Urgent and emergency care • For Integrated Urgent Care and 999 services, agree for WY&H the transformational, finance and contractual matters identified as CCG decisions to be made in collaboration across Yorkshire and the Humber. • Agree the specification, business case, commissioning and procurement process for GP out of hours services	• No relevant risks currently scored at 12 or above.				

Joint Committee work plan	Risk to delivery	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
6. Joint Committee decision-making • Joint Committee decisions are robust, with appropriate public and patient involvement, clinical engagement and quality assurance.	• No relevant risks currently scored at 12 or above.				